APPENDIX 8
PRIOR AUTHORIZATION DAY TREATMENT ATTACHMENT (PA/DTA) SAMPLE

Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/DTA

PRIOR AUTHORIZATION DAY TREATMENT ATTACHMENT

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

(1) LAST NAME	(2) FIRST NAME	(3) MIDDLE INITIAL	(4) MEDICAL ASSISTANCE ID NUMBER	(5) AGE
Recipient	Im	A	1234567890	29

PROVIDER INFORMATION

(6) REQUESTING/PERFORMING PROVIDER'S NAME AND CREDENTIALS	(7) REQUESTING/PERFORMING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER	(8) REQUESTING/PERFORMING PROVIDER'S PROVIDER TELEPHONE NUMBER
I. M. Requesting	76543210	(XXX) XXX - XXXX

(9) REFERRING/PRESCRIBING PROVIDER'S NAME	(10) REFERRING/PRESCRIBING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER
I. M. Referring	12345678

A. Number of hours per week requested 10 hrs/wk

B. Estimated final treatment date 12/92 and after

C. Has the recipient had previous Day Treatment at your facility or elsewhere?
☒ Yes ☐ No ☐ Unknown
If "Yes", list dates and locations:

Client began Day Treatment on DD/MM/YY and has had 6 months of intensive treatment.

D. Evaluation(s): (Dates, Tests Used and Results)

MM/DD/YY functional assessment
MM/DD/YY psychiatric interview
MM/DD/YY clinical interview

E. Attach page one (1) of the recipient's most recent Function Assessment Scales.
(Functional Assessment must be signed and dated within 3 months of receipt by EDS)

F. Is the recipient's intellectual functioning below average?
☐ Yes ☒ No
If "yes", what is the recipient's IQ score or intellectual functioning level, and how was this measured?

G. **Provide a brief history, pertinent to requested services (include psycho-social history, hospitalization history, family history, living situation history, etc.).**

According to available records this client has been in and out of institutions for 10 years. The active phase of her illness occurred 10 years ago. Client throughout her history has shown bizarre decisions, auditory hallucinations, loosening of associations, and inappropriate affect. This client while in the active phase, has pulled a knife on her family which warranted an emergency detention. This occurred 1 year ago. As a result, client was placed in a group home after being stabilized in the hospital. Her family currently has decided not to be involved with her.

H. Progress/status since treatment began or was last authorized:

Client is currently stabilized with medication. However periodic auditory hallucinations appear to be occurring. Client has been able to perform vocational tasks through our workshop and participates in this 2 days/wk. under stress client has a high potential of having an exacerbation of psychotic symptoms. With continued support she has been able to remain in the community.

I. Specify overall character of service to be provided:

☐ Rehabilitation ☒ Maintenance ☐ Stabilization

J. Identify measurable treatment goals:

1) The major goal of Day Treatment is to help maintain this client in the community. This will be measured by a decrease in hospitalizations.

2) Client will be supported for acceptance of her disease by continued willingness to take medications, and continued verbalizations of this in a group. This will also be measured by regular attendance in all groups..

3) Client will continue to learn ADL skills and problem solving skills. This will be demonstrated by increased independence in her group home and at her vocational placement.

4) Client will be monitored for changes in emotional, social, and task skills as measured by functional assessment.

K. Attach a specific schedule of activities, to include day, time of day, length of session and service to be provided:

See Attachment

L. Rehabilitation Potential: estimate the recipient's potential for Employment (competative, supported, sheltered, etc.) Social Interaction, Independent Living

It appears that client has reached maximum potential at this time. Because of the chronic nature of her illness, client's potential for employment is poor. However, with consistent structure, her potential placement in a sheltered workshop and independant living situation is good.

M. **Recipient Authorization**

I have read the attached request for prior authorization of Day Treatment services and agree that it will be sent to the Medicaid Program for review.

Signature of Recipient or Representative (If representative, state relationship to recipient) _____ Relationship _____

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

N. D. M. Prescribing — Signature of Prescribing Physician — MM/DD/YY — Date

I. M. Performing — Signature of Therapist Providing Treatment — MM/DD/YY — Date

Signature of 51.42 Board Director/Designee — Date